PREMERA BLUE CROSS

Outline of Medicare Supplement Coverage

Cover Page

Benefit Plans E and J

Medicare supplement coverage can be sold in only ten (10) standard plans. This chart shows the benefits included in each plan. Every company must make available Plan A. Some plans may not be available in your state. The HCA is offering Plans E and J.

BASIC BENEFITS:	Included in all plans.
Hospitalization:	Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses:	Part B coinsurance (20% of Medicare-approved expenses).
Blood:	First three pints of blood each year.

A	B	C	D	***E***	F	G	H	I	***J***
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs $1,250 limit	Basic Drugs $1,250 limit	Extended Drugs $3,000 limit
				Preventive Care					Preventive Care

65-8231/7-2002

SUBSCRIPTION CHARGES AND PAYMENT MODES:
Rates Effective January 1, 2003

	Eligibility by Age		Eligibility by Disability	
PLAN E	$ 92.70	PBC Total Monthly Rate	$148.32	PBC Total Monthly Rate
	$ 51.98	PEBB Retiree PAYS (Subscriber)	$ 79.79	PEBB Employee PAYS (Subscriber)
	$ 98.33	PEBB Retiree PAYS (Subscriber & Spouse)	$153.95	PEBB Employee PAYS (Subscriber & Spouse)
	$ 92.70	State Resident PAYS (Subscriber)	$148.32	State Resident PAYS (Subscriber)
	$ 185.40	State Resident PAYS (Subscriber & Spouse)	$296.64	State Resident PAYS (Subscriber & Spouse)
PLAN J	$233.25	PBC Total Monthly Rate	$373.20	PBC Total Monthly Rate
	$146.14	PEBB Retiree PAYS (Subscriber)	$286.09	PEBB Employee PAYS (Subscriber)
	$286.65	PEBB Retiree PAYS (Subscriber & Spouse)	$566.55	PEBB Employee PAYS (Subscriber & Spouse)
	$233.25	State Resident PAYS (Subscriber)	$373.20	State Resident PAYS (Subscriber)
	$466.50	State Resident PAYS (Subscriber & Spouse)	$746.40	State Resident PAYS (Subscriber & Spouse)

SUBSCRIPTION CHARGES INFORMATION

We, Premera Blue Cross (PBC), can only raise your subscription charges if we raise the subscription charge for all contracts like yours in this state.

DISCLOSURES

Use this outline to compare benefits and subscription charges among contracts.

READ YOUR CONTRACT VERY CAREFULLY

This is only an outline describing your contract's most important features. You must read the contract itself to understand all of the rights and duties of both you and your Medicare supplement carrier.

RIGHT TO RETURN CONTRACT

If you find that you are not satisfied with your coverage, you may return it to 7001 - 220th St. S.W., Mountlake Terrace, Washington 98043-2124. If you send the contract back to us within thirty (30) days after you receive it, we will treat the contract as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new contract and are sure you want to keep it.

NOTICE

This contract may not fully cover all of your medical costs.

Premera Blue Cross is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN E
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

***** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $812	$812 (Part A deductible)	$0
61st thru 90th day	All but $203 a day	$203 a day	$0
91st day and after:			
-- While using 60 lifetime reserve days	All but $406 a day	$406 a day	$0
-- Once lifetime reserve days are used:			
--- Additional 365 days	$0	100% of Medicare eligible expenses	$0
--- Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $101.50 a day	Up to $101.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E (continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

***** Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Medical Expenses - In Or Out Of The Hospital And Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
Clinical Laboratory Services - Blood Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

Home Health Care-Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $100 of Medicare approved amounts*****	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN E (continued)
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Foreign Travel - Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
Preventive Medicare Care Benefit - Not covered by Medicare Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

PLAN J

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

***** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $812	$812 (Part A deductible)	$0
61st thru 90th day	All but $203 a day	$203 a day	$0
91st day and after:			
-- While using 60 lifetime reserve days	All but $406 a day	$406 a day	$0
-- Once lifetime reserve days are used:			
--- Additional 365 days	$0	100% of Medicare eligible expenses	$0
--- Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $101.50 a day	Up to $101.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

***** Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Medical Expenses - In Or Out Of The Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
Clinical Laboratory Services - Blood Tests for Diagnostic Services	100%	$0	$0

PLAN J (continued)
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Home Health Care-Medicare Approved Services Medically necessary skilled care services and medical supplies Durable medical equipment First $100 of Medicare approved amounts* Remainder of Medicare approved amounts	100% $0 80%	$0 $100 (Part B deductible) 20%	$0 $0 $0
At-home Recovery Services - Not covered by Medicare Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan Benefit for each visit Number of visits covered (must be received within 8 weeks of last Medicare approved visit) Calendar year maximum	$0 $0 $0	Actual charges to $40 a visit Up to the number of Medicare approved visits not to exceed 7 each week $1,600	Balance

PLAN J (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Foreign Travel - Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
Extended Outpatient Prescription Drugs - Not covered by Medicare			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50% - $3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All costs
Preventive Medicare Care Benefit - Not covered by Medicare Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs